TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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# *-MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name**
ULTIMATE PAIN SOLUTIONS

**Respondent Name**
TEXAS MUTUAL INSURANCE CO

**MFDR Tracking Number**
M4-18-1007-01

**Carrier's Austin Representative**
Box Number 54

**MFDR Date Received**
DECEMBER 8, 2017

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Attached is all the previous documentation that had been sent in a timely manner along with the proof of the faxed confirmation."

**Amount in Dispute:** $1,925.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The requester billed code 99213-25 for date 8/2/17. Texas Mutual declined to issue payment absent documented justification for use of that modifier. The requestor billed code 97750-FC for a functional capacity evaluation. Review of the documentation shows no cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill as required by Rule 134.225. No payment is due."

**Response Submitted By:** Texas Mutual Insurance Co.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| August 2, 2017 | CPT Code 99213-25 | $125.00 | $0.00 |
| August 19, 2017 | CPT Code 97750-FC( X12) | $1,800.00 | $0.00 |
| TOTAL | | $1,925.00 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional services.
3. 28 Texas Administrative Code §134.225, effective July 7, 2016, sets the reimbursement guidelines for the disputed service.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - A07-Documentation does not meet the level of service required for FCE per rule 134.204(G)3(C).
   - CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.
   - CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
   - CAC-150-Payer deems the information submitted does not support this level of service.
   - CAC-193-Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly.
   - CAC-97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 738-FCE allowed a max of 3 times per injury (Except DWC ordered) initial = Max of 4 hrs; interim = Max of 2 hrs; Discharge = Max of 3 hrs.
   - 857-Modifier -25 billed. Documentation does not support a significant, separately identifiable E&M service.
   - 891-No additional payment after reconsideration.

**Issues**

1. Is the respondent's denial of payment for the office visit supported?
2. Is the respondent's denial of payment for FCEs supported?

**Findings**

1. The applicable fee guideline office visits is 28 Texas Administrative Code §134.203.

   According to the explanation of benefits, the respondent denied reimbursement for the office visit, CPT code 99213-25 based upon reason code "CAC-97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated," and "857-Modifier -25 billed. Documentation does not support a significant, separately identifiable E&M service."

   28 Texas Administrative Code §134.203(a)(5) states, "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   A review of the submitted bills and explanation of benefits indicate that on the date of service the requestor billed CPT code 99213-25.

   CPT code 99213 is described as "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family."

   Modifier 25 is described as "Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service."

   Is the provider's billing of modifier "25" supported?

   Medicare Claims Processing Manual, Chapter 12, (40.2)(A)(8), Billing Requirements for Global Surgery states:

   Significant Evaluation and Management on the Day of a Procedure

   > Modifier "-25" is used to facilitate billing of evaluation and management services on the day of a procedure for which separate payment may be made. It is used to report a significant, separately identifiable evaluation and management service by same physician on the day of a procedure. The physician may need to indicate that on the day a procedure or service that is identified with a CPT code was performed, the patient's condition required a significant, separately identifiable evaluation and management service above and beyond the usual preoperative and postoperative care associated with the procedure or service that was performed. This circumstance may be

reported by adding the modifier “-25” to the appropriate level of evaluation and management service.

A review of the submitted documentation finds that the requestor does not identify what procedure or service was performed on August 2, 2017 that necessitated the use of modifier 25. Therefore, the submitted documentation does not support the use of modifier 25. As a result, reimbursement is not recommended.

2. The applicable fee guideline for FCEs is 28 Texas Administrative Code §134.225.

According to the submitted explanation of benefits the respondent denied reimbursement for the FCEs based upon “A07-Documentation does not meet the level of service required for FCE per rule 134.204(G)3(C)” and “CAC-150-Payer deems the information submitted does not support this level of service”.

28 Texas Administrative Code §134.225 states:

> The following applies to functional capacity evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a division ordered test; a maximum of two hours for an interim test; and a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required. FCEs shall include the following elements:
>
> (1) A physical examination and neurological evaluation, which include the following:
> (A) appearance (observational and palpation);
> (B) flexibility of the extremity joint or spinal region (usually observational);
> (C) posture and deformities;
> (D) vascular integrity;
> (E) neurological tests to detect sensory deficit;
> (F) myotomal strength to detect gross motor deficit; and
> (G) reflexes to detect neurological reflex symmetry.
> (2) A physical capacity evaluation of the injured area, which includes the following:
> (A) range of motion (quantitative measurements using appropriate devices) of the injured joint or region; and
> (B) strength/endurance (quantitative measures using accurate devices) with comparison to contralateral side or normative database. This testing may include isometric, isokinetic, or isoinertial devices in one or more planes.
> (3) Functional abilities tests, which include the following:
> (A) activities of daily living (standardized tests of generic functional tasks such as pushing, pulling, kneeling, squatting, carrying, and climbing);
> (B) hand function tests that measure fine and gross motor coordination, grip strength, pinch strength, and manipulation tests using measuring devices;
> (C) submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill; and
>
> (D) static positional tolerance (observational determination of tolerance for sitting or standing).

A review of the submitted FCE reports finds the requestor did not document all the elements required for FCEs, specifically, “submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill”. The division finds the respondent’s denial is supported and reimbursement is not recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that reimbursement is not due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| | | |
|---|---|---|
| | | 12/20/2017 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

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Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.